

June 11, 2002

Re: Medical Dispute Resolution
MDR #: M2-02-0498-01
IRO Certificate No.: IRO 5055

Dear

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). Texas Workers' Compensation Commission Rule 133.308 "Medical Dispute Resolution by an Independent Review Organization", effective January 1, 2002, allows an injured employee, a health care provider and an insurance carrier to appeal an adverse determination by requesting an independent review by an IRO.

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ___ for an independent review. ___ has performed an independent review of the medical records to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Anesthesia/Pain Management.

THE PHYSICIAN REVIEWER OF THIS CASE **AGREES** WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE.

I am the Secretary and General Counsel of ___ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by ___ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within ten (10) days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC

Chief Clerk of Proceedings within twenty (20) days of your receipt of this decision (28 Tex. Admin. Code 148.3.

This Decision is deemed received by you five (5) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on November 26, 2002.

Sincerely,

MEDICAL CASE REVIEW

This is for _____. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0498-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Medical Dispute Resolution Request and Response.
2. Notes pertaining to this case from _____.
3. Physical and neurological examination on admission to _____.
4. Lumbar spine x-rays from Diagnostic Neuro Imaging.

B. SUMMARY OF EVENTS:

This patient is being followed for a chronic lumbar radiculopathy. He is status post L4-S1 fusion which was done in April of 2000. He is currently on Celebrex, hydrocodone, Flexeril and Valium. He has been continuing to have significant pain. _____ feels that he has positive facet syndrome on physical examination, and has asked for facet injections to be done. These have been denied, and an appeal was done. The appeal also suggested denial.

C. OPINION:

I AGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER ON THIS CASE THAT DENIAL IS APPROPRIATE FOR LUMBAR FACET INJECTIONS AS REQUESTED.

The reasons for my agreement are that there is insufficient documentation of failed conservative treatment such as exercise-based rehab and home exercise program. There is also a previous facet injection that was done which gave no relief, and there is also no explanation of how the facet injections at this time will impact him on a more permanent basis.

D. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 11 June 2002